tumours is less well reported. We report our initial experience of managing multiple small renal tumours with cryotherapy in high risk patients with considerable co-morbidities.
Materials and methods: In 18 months, we treated 2 patients with multiple small renal tumours with laparoscopic cryoablation. They both had significant comorbidities (ASA3), but maintained an active quality of life. A transperitoneal approach was used in both. Four and three ipsilateral renal tumours ranging from 10mm to 30mm were treated with 5 and 4 cryotherapy needles (2.4mm) respectively. The treatment included double 10 minute freeze-thaw cycles. The treatment was carried out under vision and laparoscopic ultrasound guidance.
Results: The operation times were 170 and 300 minutes, with minimal blood loss and no complications. The hospital stay was 2 and 5 days. The estimated GFR did not change. There is no radiological evidence of recurrence in one patient at 20 months, the second patient approaches 6 months follow-up.
Conclusion: Cryotherapy is an alternative safe treatment option for multiple small renal tumours in high risk candidates.

PATIENT PERCEPTIONS OF URODYNAMIC INVESTIGATION

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Introduction: Patients are considerably anxious before urodynamic investigations (UDSI). Anecdotally, patients' perceptions of UDSI improve following the test. The aim of this study is to investigate patients' perceptions before and after UDSI.
Method: 80 consecutive patients recorded their pre-test anxiety level on a 10cm visual analogue scale (VAS) ranging from "not at all anxious" to "extremely anxious". Immediately after UDSI, all patients were asked to record on the VAS the level of anxiety they felt towards UDSI being repeated. A two-tailed t-test was performed to identify any difference between pre and post test VAS.
Results: 31 males and 49 females (25-82 years, mean 58.53 years) were included in the study. All had the procedure explained to them before completing the VAS. VAS reduced post-test in 58, increased in 8 and remained unchanged in 14 patients. The mean pre-test score (3.93) was significantly greater than the mean post-test score (1.69), (mean difference = 2.25, SD = 2.47); t stat = 8.14, $p<0.001$, suggesting that patients' perceptions regarding further UDSI testing is improved.
Conclusion: 72.5% of patients were less anxious about having a repeat UDSI. This information can be used in future to reassure patients.

A SINGLE–INSTITUTION EXPERIENCE IN USE OF BACILLE CALMETTE-GUERIN (BCG) IN SUPERFICIAL BLADDER CANCER

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Introduction: Intravesicle BCG decreases the risk of progression in bladder cancer. The aim of the study was to assess if maintenance BCG is reliably achieved beyond 12 months.
Methods: Between April 2005- August 2008, 54 patients were started on BCG maintenance therapy. We analyzed patient case notes, and assessed the duration of BCG treatment as our primary measure, and reasons for failure to complete maintenance and clinical outcome as secondary measure.
Results: Of the 54 patients identified, 16 (26.6%) had low risk, 10 (18.5%) intermediate risk and 28 (51.9%) had high-risk superficial bladder cancer. Only 12 (22.2%) completed the full course of maintenance treatments at 6 monthly intervals. 28 (51.9%) completed at least 12 months of maintenance therapy. Of 14 (25.9%)patients who failed to complete 12 months of BCG maintenance therapy, 7(50%)had disease progression, 5(35.7%) had BCG related side effects and 2(14.3%)died. Of 5 patients who stopped treatment due to side effects, 4 of then had progression of disease. Out of the 11 patients who had disease progression, 4(36.4%) underwent cystectomy.
Conclusion: Initial BCG therapy and cystectomy could the answer for high drop off rates and toxicity with use of maintenance BCG in High-grade superficial bladder cancers.

ROUTINE EARLY POST-OPERATIVE DUPLEX SCANNING IS UNNECESSARY FOLLOWING CAROTID ENDARTERECTOMY

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Introduction: The primary aim of the study was to determine whether routine early duplex scanning following carotid endarterectomy (CEA) is beneficial in identifying recurrent or residual disease and whether it has any role in preventing further neurological events.
Methods: A retrospective review of patient case-notes was performed on all patients undergoing CEA between January 2001 and March 2008. Patients had post-operative duplex scans within 3 months of surgery.
Results: There were 184 CEA operations performed during the assessed period. The mean patient age was 68 years (range 49-88 years). Male to female ratio was 127:57. Of these 127 were performed under general anaesthesia and 57 under local anaesthesia. Three patients (1.6%) died in the early post-operative period. Abnormalities were detected in 9 (10.3%) cases. Two had occlusions, 2 ulceration, 1 thrombus, 8 with residual stenosis of 50-60%, and 6 with a residual stenosis of 60-70%. None of the scanned patients had clinical symptoms related to the carotid territory on which had been operated.
Discussion: These results show that early post-CEA duplex scanning is of limited clinical value. However, this practice is reassuring for the patient and provides good documentary evidence of quality control and the technical abilities of surgical trainees.

BENCHMARK ASSESSMENT VERSUS LOCAL AUDIT FOR THE MANAGEMENT OF PATIENTS WITH POTENTIALLY CURATIVE OESOPHAGO-GASTRIC CANCER

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Aims: North of Scotland Cancer Network (NOSCAN) have used a benchmark assessment (BA) to report current practice and service quality for patients with oesophago-gastric (OG) cancer in the North of Scotland. The assessment was based on SIGN 87 (management of OG cancer, 2006). Our aim was to compare results of BA against a local audit for the management of patients with potentially curative OG cancer.
Methods: A retrospective audit was performed of patients referred with potentially curative OG cancer (March 2005 – March 2009). Data extracted included the 69 recommendations detailed in the NOSCAN assessment. The audit data was compared to the BA response.
Results: 75 consecutive patients underwent potentially curative resection (oesophageal [n = 25], junctional [n = 26] and gastric [n = 24]). The BA